Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Denton

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-0809-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 31, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Denton to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery."

Amount in Dispute: $2,397.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The NCCI Edits for hospitals indicated code 14041 is bundled to code 96365. Although the Edits indicate as well that a modifier can be used with code 14041, the requestor's bill fails to show a modifier used with 14041. No additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2014	Outpatient Hospital Services	$2,397.24	$2,397.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers Compensation State Regulation/Fee Schedule Requirements
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 432 – A comprehensive CCI code has been paid on a bill in permanent history that should have been

bundled

- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 193 – Original payment decision is being maintained

Issues

1. Is the respondent's denial of the services in dispute supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, 236 – "This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers Compensation State Regulation/Fee Schedule Requirements." 28 Texas Administrative Code §134.402 (d) states in pertinent part, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs." The respondent states, "The NCCI edits for hospitals indicates code 14041 is bundled to code 96365." Review of the NCCI edits finds ;

    a. Column One - 14041 Column Two - 96365 Effective Date – 20090101 Modifier - 1

    b. Modifier Indicator Table MODIFIER INDICATOR DEFINITION

    0 (Not Allowed) There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.

    c. 1 (Allowed) The modifiers associated with NCCI are allowed with this code pair when appropriate.

    d. 9 (Not Applicable)

    e. MedLearn Matters Document titled, "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools." States in pertinent part, "When is a code the reimbursable code of a NCCI code pair? The Column 1/Column 2 tables are comprised of code pairs. If a provider submits the two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1 code is **eligible** for payment and the Column 2 code is denied. However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. Supporting documentation must be in the beneficiary's medical record."

    As the disputed service is in column one, this service is eligible for payment. The disputed services will be reviewed per applicable rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

    - Procedure code 11043 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%.

This procedure is paid at 50%. These services are classified under APC 0016, which, per OPPS Addendum A, has a payment rate of $274.81. This amount multiplied by 60% yields an unadjusted labor-related amount of $164.89. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $159.23. The non-labor related portion is 40% of the APC rate or $109.92. The sum of the labor and non-labor related amounts is $269.15. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $134.58 divided by the sum of all S and T APC payments of $1,715.63 gives an APC payment ratio for this line of 0.078443, multiplied by the sum of all S and T line charges of $6,293.50, yields a new charge amount of $493.68 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $134.58. This amount multiplied by 200% yields a MAR of $269.16.

- Procedure code 14041 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0328, which, per OPPS Addendum A, has a payment rate of $1,371.19. This amount multiplied by 60% yields an unadjusted labor-related amount of $822.71. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of $794.49. The non-labor related portion is 40% of the APC rate or $548.48. The sum of the labor and non-labor related amounts is $1,342.97. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,342.97 divided by the sum of all S and T APC payments of $1,715.63 gives an APC payment ratio for this line of 0.782785, multiplied by the sum of all S and T line charges of $6,293.50, yields a new charge amount of $4,926.46 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,342.97. This amount multiplied by 200% yields a MAR of $2,685.94.

4. The total allowable reimbursement for the services in dispute is $2,955.10. The carrier previously $538.31. The requestor is seeking $2,397.24. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,397.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,397.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.